

A discussion of a patient's care using two of Chapelhow et al.'s enablers

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Abstract

The application of the Chapelhow framework for a female patient experiencing an ectopic pregnancy, focusing on the assessment and communication elements of patient care. Further exploring the patient's journey from the emergency room to the ward, discussing the investigations and pathways utilised throughout and providing the rationale behind the decisions made. Highlighting the good and poor aspects of holistic care provided and the impact on the patient and her partner. Finally evaluating the standard of assessment and communication as high, however recommendations to focus further on patient-centred care, to minimise anxiety and distress for the patient during a difficult time and improvements made to teamwork amongst the multidisciplinary team.

Keywords

Chapelhow; assessment; communication; patient care; ectopic pregnancy

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The Chapelhow et al (2005) template is comprised of several components which allow the reader to learn and understand a new skill whilst reflecting on their learning throughout the process. They have created a Meaningful Assimilation of Skills for Care model (MASC) (Chapelhow et al. 2005) that identifies the fundamental elements of skill delivery. To effectively use the template and the model, whilst applying it to practice they have identified six “enablers”. For the purpose of this article I’ll focus on two of these “enablers”: assessment and communication (Chapelhow et al. 2005).

Verbal consent was sought from a patient to undertake this study. To maintain confidentiality pseudonyms are used calling the patient Kate and her partner Rob. Kate is a 29 year old florist, married to Rob for four years. They have no children but Kate has experienced two miscarriages, in 2011 and 2013. Kate’s only medical history was a dislocated knee from an accident aged 13. She was otherwise fit and healthy, had no known allergies and was a non-smoker. An accurate patient history is an important diagnostic tool (Cox 2010).

Throughout this study there will be critical discussion of the assessment and communication methods used during the patient’s journey. All statements will be supported by the literature and there will be a focus on patient-centred care. There will be reflection on learning to provide a greater understanding of the experience (Chapelhow et al. 2005).

The initial assessment was conducted when Kate presented at the emergency room (ER). It was in the form of verbal questioning and was comprised of various questioning styles. Closed questions were used to gather specific details (Sully and Dallas 2010) and establish baseline information (Howatson-Jones, Standing and Roberts 2012). A series of open questions was used to identify the problem (Howatson-Jones, Standing and Roberts 2012) and allow the patient to describe her experience and feelings (Sully and Dallas 2010). Listening and remaining silent are essential techniques when building a therapeutic relationship (Doherty and Thompson 2014). The initial assessment identified Kate's symptoms as a period of amenorrhea (Tortora and Derrickson 2011), a positive pregnancy test (NICE 2014) along with abdominal pains (NICE 2014) and vaginal bleeding (McQueen 2011).

Kate waited two hours before a physical examination, she became quite distressed. This was apparent in her behavioural observations as Kate became restless and irritable (Arnold and Underman Boggs 2011). During this wait Kate's observations were taken and recorded; all results were within acceptable ranges in accordance with Modified Early Warning System (MEWS) (Dougherty and Lister 2011). The MEWS chart is now being phased out and a National Early Warning System (NEWS) chart being implemented (McFerran 2014). It allows detection of a deteriorating patient by monitoring and recording six physiological parameters (Howatson-Jones, Standing and Roberts 2012, McFerran 2014), it's a valuable tool for continuous assessment.

In accordance with the NICE (2012) pathway for ectopic pregnancy and miscarriage an abdominal examination was performed. It identified tenderness focussed mainly on the left iliac fossa but no adnexal mass was located (Marquardt 2011). The next method of patient assessment was a bimanual examination which revealed cervical motion tenderness (Marquardt 2011). A speculum examination could have been performed to inspect the vaginal walls and the cervix (Cox 2010) which may have provided further information to lead to a quicker diagnosis. Kate was showing signs of an ectopic pregnancy and the ER then had to communicate with the ward to secure a bed so further assessment and observation could be conducted.

Further attention to patient-centred care could have been given keeping the patient informed on the prognosis. Patient-centred nursing involves the development of a therapeutic relationship which is based upon trust and understanding (McCormack and McCance 2010). Sully and Dallas (2010) state that when a patient is distressed the same information may need to be repeated on numerous occasions. Kate was informed of the investigation, there was very little choice or patient input at this stage which could have been improved. During transfer to the ward effective communication was required for an accurate handover. The ward staff were introduced to Kate, her symptoms were described together with the assessments that had been conducted, their findings and her current status in relation to the NEWS chart (Cox 2010). Cox (2010) states that the presentation of a new patient should be conducted clearly, confidently and with the aid of good written notes.

Kate was introduced to the ward and staff who would be caring for her. Due to the sensitive nature of Kate's admission she could have been allocated a room, which would have provided her with privacy. Kraszewski and McEwen (2010, pp.26-28) characterise a sensitive issue as any matter that causes some degree of embarrassment or emotional discomfort that a person finds difficult to talk publically about. Unfortunately her partner Rob was unable to stay with her. Removing Kate's social support in such a stressful situation could have affected her emotional state and wellbeing. Arnold and Underman Boggs (2011) claim sharing problems with others helps to reduce stress and a support network can provide tangible encouragement. The absence of her partner could have contributed to a decline in Kate's physical and mental health. If she had been allocated a room, her partner would have been able to stay.

Kate's observations were taken and recorded again, all readings remained within normal tolerances. Kate was complaining of worsening pain. The intensity of the pain was assessed using a numerical rating scale and verbal descriptor scales (Dougherty and Lister 2011). No assessment of dynamic pain was carried out, nor was a reading for static pain obtained (Dougherty and Lister 2011). Other assessments of pain could have been carried out in the form of a questionnaire as it gives the patient more involvement, which is valuable as healthcare professionals frequently underestimate pain (Dougherty and Lister 2011). Appropriate analgesia was prescribed to be taken with sips of water. There was a delay in the prescription being submitted on the system, which in turn delayed the administration of the analgesia. This lack of effective communication could have caused a physical deterioration in Kate. Since a diagnosis of ectopic pregnancy was still

outstanding, it was advised that Kate should remain nil by mouth in case she needed surgery (Farquhar 2011). To prevent Kate from becoming dehydrated an intravenous drip was put in place, and a fluid balance chart was started as a method of assessment. Sanitary pads were provided for Kate so per vagina (PV) loss could be monitored. A urine and blood sample were collected for further tests and to aid a diagnosis.

The Malnutrition Universal Screening Tool (MUST) was used during the first part of Kate's admission assessment. It uses a patient's body mass index, using accurate height and weight measurements to identify the overall risk (Howatson-Jones, Standing and Roberts 2012). Kate scored a 0, therefore no referral to a dietician was necessary. A Waterlow assessment was conducted to identify the risk of Kate developing a pressure ulcer (Dougherty and Lister 2011). Due to the fact Kate was mobile and continent, along with other parameters, the Waterlow assessment identified her as low risk, no further intervention was required. Finally we used Roper, Logan and Tierney's 'Activities of Daily Living' model to assess Kate (Roper, Logan and Tierney 2000). This model considers twelve factors which encompass daily living. It enables planning of nursing interventions for each area such as communicating, eating and drinking, mobilising and elimination (Howatson-Jones, Standing and Roberts 2012). To ensure the highest standard of patient-centred care was achieved Neuman's system could have been a beneficial assessment tool. It encompasses physiological, psychological, sociocultural, developmental and spiritual needs allowing stressors to be identified and holistic nursing interventions planned (Howatson-Jones, Standing and Roberts 2012). Comfort charts were also completed and updated two-hourly, to ensure patient wellbeing.

An ultrasound was booked as a further method of assessment. The long waits and uncertainty could have caused Kate further anguish and the risk of rupture of the fallopian tube if it was in fact an ectopic pregnancy. The urine sample confirmed levels of human chorionic gonadotropin (HCG) confirming pregnancy. The blood test results confirmed the full blood count had no abnormalities and the cross match confirmed that Kate was blood group A and was rhesus negative. If a foetus is rhesus positive it needs to be identified and documented as anti-D immunoglobulin may need to be administered (McFerran 2014, Marquardt 2011). The beta HCG levels were recorded and monitored. They were 6000IU/L.

Another diagnostic assessment for an ectopic pregnancy is dilation and curettage. This is performed under a general anaesthetic, the cervix is dilated and curettings are obtained by scraping tissues from the lining of the uterus (McQueen 2011). This procedure is not widely used as it is invasive and carries a risk of adverse events (Farquhar 2011).

After a two hour wait Kate was taken for a vaginal ultrasound. Communication between the multidisciplinary team was poor at this stage as limited prior notice was given and the procedure felt rushed. Patient-centred care was overlooked at this point as there was minimal patient input. The purpose of the scan is to locate the pregnancy (McQueen 2011) and identify a fetal pole and heartbeat (NICE 2014). There was a delay in reviewing the scan, which may have led to increased anxiety for Kate. A team briefing was held to discuss the findings of the ultrasound and to enhance the collaboration and communication throughout the multidisciplinary team (Arnold and Underman Boggs

2011). There was nothing in utero (RCN 2014), it was noticed that there was thickened endometrium and there was also a substantial amount of free pelvic fluid (RCN 2014).

Kate was informed of the findings to give her the opportunity to discuss her treatment options. There was a lack of privacy due to the ward setting; the only barrier between Kate and other patients was the curtains (Kraszewski and McEwen 2010, pp.49-50). The environment could have had a negative impact on Kate as she was lying on the bed and three members of staff stood around her bedside. This could be an intimidating setting. The delivery of bad news is not an easy task (Kraszewski and McEwen 2010, pp.28-30). It could have been improved by an increase in empathy shown, which is a vital communication skill and aids relationship building (Kraszewski and McEwen 2010, p.24). Nursing care was vital here to provide comfort and reassurance to Kate, non-verbal communication skills were utilised to actively listen and the use of touch demonstrated warmth and compassion (Kraszewski and McEwen 2010, p.33).

Medical jargon was used when advising Kate of the possible treatment options, to overcome this communication barrier careful explanations should be used (Arnold and Underman Boggs 2011). Due to the time constraints around an ectopic pregnancy and Kate's worsening pain not enough explanation was given. More patient-friendly terminology could have been used. Kate should have been allowed more time to make her decision, given her partner's absence and the distressing nature of the diagnosis. After a telephone conversation with her partner they decided to opt for a laparoscopic salpingectomy.

A venous thromboembolism (VTE) test was completed to establish Kate's risk of developing a deep vein thrombosis (DVT) (Dougherty and Lister 2011). It provided Kate with a score of 1, which is categorised as low risk (Dougherty and Lister 2011). She was required to wear antiembolic stockings to prevent the onset of DVT's (Dougherty and Lister 2011) and a gown was given to Kate to wear whilst in theatre. Consent forms were provided for the laparoscopic salpingectomy (Dougherty and Lister 2011) and for disposal of fetal remains. Once the forms were completed we began to prepare Kate for theatre. Another set of observations was taken. All of these were within the normal range. Kate was then escorted to theatre.

Theatre recovery called to advise us that Kate was ready to be collected. The operation was successful. Kate was very tired, but pain free. Her observations were then monitored and recorded. Her blood pressure was slightly high at 179/85mmHg (Dougherty and Lister 2011) but all other readings were within normal ranges, her PV loss was slight. Once awake Kate tolerated a cup of tea and some toast and we monitored her fluid balance. When Kate was able to void urine and tolerate foods consistently we began to discharge her. A letter was sent to her GP, a two week sick note was written up for Kate and analgesia from the pharmacy was prescribed for Kate to take home. Advice and leaflets were given to Kate and Rob for ongoing support (McQueen 2011) along with contact numbers of relevant services. Kate was advised to complete a pregnancy test in three weeks' time and contact the ER if the result came back positive (NICE 2012). No follow-up appointment was required.

It was felt that assessment and communication throughout this patient's journey was of a high standard. However there could have been more focus on patient-centred care to ensure Kate was at the forefront of her own treatment regime and did not encounter feelings of anxiety or distress. Furthermore teamwork and communication throughout the multidisciplinary team could have been improved to ensure efficiency and patient wellbeing. The importance of assessment and communication in delivering a high standard of nursing care is now clear. Providing information tailored to the patient's needs is equally important.

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